Nourish'd
Wellness Center and Spa

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Post Micro Roller Instructions

INFORMED CONSENT

Intravenous or IM Therapy: aka Vitamin Drip Therapy, Vitamin Infusion

This procedure is recommended for replacement of essential nutrients, correction of deficiencies, and for other therapeutic effects, such as improving immune function, improving antioxidant status, reducing oxidative damage, decreasing bronchospasm, improving fatigue, etc.

The principal side effects that may accompany intravenous administration of nutrients include:

-burning and stinging at the site of infusion or if IV infiltrates into surrounding tissue

-muscular spasms, weakness, or fatigue

-allergic reactions, for example a rash or swelling near the injection site (Rare)

-local thrombophlebitis (very rare).

This procedure may be considered medically unnecessary. It may or may not mitigate, alleviate, or cure the condition for which it has been prescribed. This therapy has been recommended to you in the belief that it is of potential benefit in these circumstances and its use may improve the condition for which you are under treatment and in your overall health.

I understand that my treatment records and test results may be used as the basis for a published study and consent to such use of my treatment results. I further understand and agree to adhere to the treatment schedule and attend the follow-up visitations set by my medical provider to permit observation of my progress. I understand that I may suspend or terminate my treatment at any time by informing my medical provider. I assume full liability for any adverse effects that may result from the non-negligent administration of the proposed treatment. I waive any claim in law or equity for redress of any grievance that I may have concerning or resulting from the procedure, except as that claim pertains to negligent administration of this procedure. The risks involved and the possibilities of complications have been explained to me. I fully understand and confirm that the nature and purpose of the aforementioned treatment to be provided may be considered unproven by scientific testing and peer-reviewed publications and therefore may be considered medically unnecessary or not currently indicated.

After Care Issues: (417) 753-7642,
If severe please call 911 or go to the closest Emergency Room

The amount of vitamin injected is an estimate of the amount of Vitamin required to effect change. I understand there is no guarantee of results of any treatment. I understand the regular charge applies to all subsequent treatments.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection, and/or court cost and reasonable legal fees, should this be required.

IF Before and after photos are necessary and mandatory at Nourish'd Wellness Center and Spa; client pictures are submitted electronically to our ARNP, or PA and in most cases an MD. Pictures will be kept on file for a minimum of seven years. These photos may be seen by any Nourish'd Wellness Center & Spa members for educational purposes. All Nourish'd Wellness Center & Spa staff members are professionals and are bound by their own colleges regarding patient confidentiality. In some cases, Nourish'd Wellness Center & Spa will live stream injections to its internal members for the purpose of training only and no recording will take place.

This list is not meant to be inclusive of all possible risks associated with Intravenous Therapy as there are both known and unknown side effects associated with any medication or procedure.

By signing below, I acknowledge that I have read this "Informed Consent" and agree to the treatment with its associated risks. I hereby give consent to perform this and any subsequent treatments with the above understood.

I hereby place myself under your care for intravenous vitamin therapy, and agree to the above release. I also verify that all information presented to medical providers in my medical history is true to the best of my knowledge. I am not misrepresenting myself and I place myself under your care for the sole purpose of treatment for these conditions.

I hereby acknowledge that I understand that my Insurance coverage, including Medicare, will not pay for this Non-covered service, and that all services ancillary to this treatment may be also Non-covered services and Non-reimbursable. I agree to be responsible for payment at the time of service for all services, including Non-covered services.

Signed: _____ Date: _____